

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13325 Dowell Road Solomons, MD 20688	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure that the supervision and behavioral interventions implemented for Resident #11 were sufficient to prevent a resident-to-resident altercation. This was evident for 1 of 2 residents reviewed for accidents (Resident #11) and resulted in harm to Resident #9. The findings include: Review conducted on 7/8/26 at 2:06 p.m. of the facility-reported incident dated 3/27/26 revealed that witnesses observed Resident #11 push Resident #9 while Resident #9 was standing, causing Resident #9 to fall to the floor. The incident report identified GNA #5 as the staff member who witnessed the incident. Resident #11 was admitted to the facility on [DATE] with diagnoses including dementia with agitation, dementia with behavioral disturbance, dementia with psychotic disturbance, generalized anxiety disorder, psychosis, and chronic pain. Review conducted on 7/8/26 at 5:40 a.m. of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively impaired and was coded as having no behavioral symptoms, no rejection of care, and no wandering. Review conducted on 7/8/26 at 5:40 a.m. of Resident #11's care plan revealed: A care plan initiated on 5/13/24 and reviewed on 3/17/26 identified Resident #11 as an elopement risk/wanderer related to disorientation to place, impaired safety awareness, and wandering aimlessly. A care plan initiated on 6/17/24 and revised on 3/17/26 identified Resident #11 as resistive to care related to dementia, including resistance to changing clothes and bathing. A care plan initiated on 7/29/24 identified Resident #11 as having the potential to become physically aggressive related to dementia, becoming aggressive over food items, and experiencing periods of agitation. A care plan initiated on 9/9/24 identified Resident #11 as having behavioral problems including pacing, wandering, disrobing, inappropriate verbal responses, crying, violence and aggression toward staff and others, carrying clothing and blankets, refusing staff assistance with dressing, purposefully sitting on the floor, and utilizing utensils aggressively. A care plan initiated on 7/11/24 identified Resident #11 as having impaired cognitive function and impaired thought processes related to dementia. Review of the care plan further revealed interventions including monitoring Resident #11 for behavioral triggers, administering medications as ordered, psychiatric follow-up, redirecting during episodes of agitation, supervising meals, separating the resident from others during meals when indicated, and utilizing diversion and de-escalation techniques. Review conducted on 7/8/26 at 6:14 a.m. of a progress note dated 6/8/25 documented by LPN8 revealed, Resident agitated, attempting to run from staff. Swinging at staff when attempting to come near her. Trying to medicate with prn Ativan. Will continue to try. Ativan, an anti-anxiety medication, was documented as being attempted on an as-needed basis. Review conducted on 7/8/26 at 6:15 a.m. of a progress note dated 7/16/25 documented by LPN8 revealed, Resident agitated was eating lunch got up from [their] chair went after another resident with a fork. Started yelling at the (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 215270
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F 0689 Level of Harm - Actual harm Residents Affected - Few	other resident to get out. Residents separated and this resident given prn Ativan 0.5 mg by mouth. The Nurse Practitioner was on unit and gave orders to increase resident's Ativan to three times a day. Review conducted on 7/8/26 at 5:51 a.m. of a progress note dated 7/10/25 documented by (Registered Nurse) RN6 revealed, Resident continues with physical aggression pushing and hitting at staff. Resident being monitored for GDR of Seroquel. Resident ambulating throughout the unit with blankets in their] hands. Resident wandering aimlessly into other rooms. Staff continue to redirect resident with no improvement. Resident becomes agitated and runs away from the staff or pushes staff away. Review conducted on 7/8/26 at 6:13 a.m. of a progress note dated 8/8/25 documented by RN6 revealed, Resident continues to pick at the area. Staff attempted to clean and file fingernails. Resident became agitated and ran down the hallway. Staff provided snacks, fluids and activities for redirection with no improvement. Review conducted on 7/8/26 at 5:50 a.m. of a progress note dated 11/10/25 documented by RN6 revealed, Resident agitated and coming down the hallway. Staff attempted to provide assistance . Resident refused treatment. Nurse attempted to administer medication for anxiety and resident refused. Staff allowed resident time to adjust in a quiet area then reapproached resident. Review conducted on 7/8/26 at 6:10 a.m. of a progress note dated 11/13/25 documented by RN6 revealed, Resident agitated and slowly running down the hallway when [they] hit caddy face first . Resident received prn Ativan for anxiety with good effect. Review conducted on 7/8/26 at 6:03 a.m. of a progress note dated 3/12/26 documented by NP21 revealed, Patient is agitated . Continues to ambulate independently . Mood is generally stable, but [he/she] does have times of increased agitation. Review conducted on 7/8/26 at 5:57 a.m. of a progress note dated 3/23/26 documented by RN6 revealed a new order for Resident #11 to be placed on close supervision with 15-minute safety checks. The note further documented Resident #11 was wandering throughout the unit and staff were encouraged to keep the resident within line of sight in the day room or in front of the nurses' station for close supervision. Review conducted on 7/8/26 at 5:57 a.m. of a progress note dated 3/23/26 documented by RN6 revealed a new physician's order placing Resident #11 on close supervision with 15-minute safety checks following the resident-to-resident altercation. The note further documented staff were instructed to encourage Resident #11 to remain within line of sight in the day room or in front of the nurses' station for close supervision. Review conducted on 7/8/26 at 6:03 a.m. of a progress note dated 3/24/26 documented by NP21 revealed, seen for agitation and aggressive behaviors . Pts behaviors have been worsening, often aggressive with staff and other residents. There is concern for pt harming herself or others. Resident #9 was admitted to the facility with diagnoses including dementia with behavioral disturbance, difficulty walking, history of falls, and cognitive communication deficit. Review conducted on 7/8/26 at 5:15 a.m. of a nurses' progress note dated 3/22/26 documented by LPN4 revealed, This resident was ambulating by the nursing station, when another resident push(ed) him/her to the wall and hit his/her head and fell buttocks' on the floor. Resident having difficulty standing. Review conducted on 7/8/26 at 5:13 a.m. of a progress note dated 3/22/26 documented by Nurse Practitioner (NP3) revealed, Primary Chief Complaint: Fall Without Injury. History of Present Illness: Consulted for fall with injury. Per nursing, resident was walking with walker and another resident made bodily contact with this resident. This led to a fall to the floor where resident made contact with their head. [the resident] is no longer able to walk which is a change from baseline. Resident was pushed to the wall hit his head and fell on the floor. Resident ambulate is having difficulty standing Appears to be in pain. The assessment further documented an acute diagnosis of unspecified injury of the head with neuro changes following the fall and indicated the resident would be transferred to the emergency department for further evaluation. During interview on 7/9/26 at 9:06 a.m., (MDS Coordinator) MDS22 indicated they (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	assessments should accurately reflect the resident's condition. During interview with the Director of Nursing on 7/10/26 at 10:00 a.m., the Director of Nursing indicated Resident #11 was currently prescribed Rexulti, an atypical antipsychotic medication, which had been effective. The Director of Nursing stated Resident #11 continued to wander but was calm, no longer ran through the hallways, and the previous mumbling had subsided. The Director of Nursing indicated the facility currently utilized distance supervision with constant visualization after determining one-to-one supervision increased the resident's agitation. The Director of Nursing further stated staff identified that Resident #11's agitation often indicated the need to use the restroom and began assisting accordingly. The Director of Nursing stated the facility consistently assigned staff members with whom Resident #11 responded well and replaced metal utensils with plastic utensils due to the resident's previous attempt to use a fork toward another resident.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure the Quarterly Minimum Data Set (MDS) assessment accurately reflected Resident #11's wandering and behavioral symptoms for 1 of 1 resident reviewed for MDS accuracy (Resident #11). Findings included: Resident #11 was admitted to the facility on [DATE] with diagnoses including dementia with agitation, dementia with behavioral disturbance, dementia with psychotic disturbance, generalized anxiety disorder, and psychosis. Review conducted on 7/8/26 at 5:40 a.m. of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively impaired and was coded as having no behavioral symptoms, no rejection of care, and no wandering. Review conducted on 7/8/26 at 5:40 a.m. of Resident #11's care plan revealed: A care plan initiated on 5/13/24 and reviewed on 3/17/26 identified Resident #11 as an elopement risk/wanderer related to disorientation to place, impaired safety awareness, and wandering aimlessly. A care plan initiated on 6/17/24 and revised on 3/17/26 identified Resident #11 as resistive to care related to dementia, including resistance to changing clothes and bathing. A care plan initiated on 7/29/24 identified Resident #11 as having the potential to become physically aggressive related to dementia, becoming aggressive over food items, and experiencing periods of agitation. A care plan initiated on 9/9/24 identified Resident #11 as having behavioral problems including pacing, wandering, disrobing, inappropriate verbal responses, crying, violence/aggression toward staff and others, carrying clothing and blankets, refusing staff assistance with dressing, and utilizing utensils aggressively. A care plan initiated on 7/11/24 identified Resident #11 as having impaired cognitive function and impaired thought processes related to dementia. Review conducted on 7/8/26 at 5:41 a.m. of the Documentation Survey Report for March 2026 revealed Resident #11 was being monitored for behavioral symptoms during the Quarterly MDS assessment look-back period. The report documented the following: On 3/12/26 at 10:57 p.m., GNA13 documented wandering. On 3/13/26 at 1:59 p.m., GNA9 documented repeated movement and wandering. On 3/14/26 at 12:24 a.m., GNA10 documented wandering. On 3/14/26 at 3:59 p.m., GNA10 documented rejection of care and pinching, scratching, and spitting. On 3/15/26 at 4:39 a.m., GNA12 documented wandering. On 3/15/26 at 1:59 p.m., GNA11 documented grabbing and wandering. On 3/15/26 at 5:06 p.m., GNA11 again documented grabbing and wandering. Review conducted on 7/8/26 at 6:03 a.m. of a progress note dated 3/12/26 documented by NP21 revealed, [AGE] year-old female seen for monthly visit and follow up. Today, patient is agitated. Continues to ambulate independently. Mood is generally stable, but she does have times of increased agitation. Review conducted on 7/8/26 at 5:44 a.m. of a progress note dated 3/12/26 documented by LPN7 revealed Resident #11 refused vital sign checks. During interview on 7/8/26 at 11:27 a.m., LPN14 indicated Resident #11 was confused and paced and walked throughout the facility. LPN14 stated Resident #11 wandered daily, had a wander guard in place, and would become aggressive, physically run down the hallway, fight, yell, and curse at staff daily. LPN14 indicated these behaviors had occurred for approximately one year prior to the resident-to-resident incident. LPN14 further stated Resident #11 had bitten them while medications were being administered approximately in February 2026. During interview on 7/8/26 at 1:48 p.m., RN6 indicated Resident #11 had dementia, was confused, wandered throughout the facility daily carrying blankets and personal belongings, became agitated when staff attempted to remove the belongings, grabbed staff during care, and at times refused medications. During interview on 7/8/26 at 2:05 p.m., LPN15 indicated Resident #11 wandered daily throughout the facility. LPN15 stated Resident #11 would walk or jog rapidly through the hallway when upset, frequently came to the nurses' station (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mumbling, and at times refused care and medications. During interview on 7/9/26 at 9:08 a.m., MDS22 indicated Resident #11 had psychiatric diagnoses, cognitive deficits, wandered daily with a wander guard in place, walked independently without an assistive device, and exhibited behaviors including yelling, striking out, swatting at staff, anxiety, and screaming. During interview on 7/9/26 at 11:23 a.m., LPN17 indicated Resident #11 wandered daily, had a wander guard in place, was exit seeking, wandered throughout the day, became agitated and combative with staff and residents, spit on staff, entered other residents' rooms, removed residents' belongings, hit and kicked staff during care, became violent when redirected, swung at other residents, and at times refused medications. During interview on 7/9/26 at 1:10 p.m., GNA24 indicated Resident #11 ambulated independently without an assistive device, would get up and take off, was combative every day, scratched and struck staff with fists, wandered throughout the facility with a wander guard in place, and became combative toward other residents. During interview on 7/9/26 at 11:52 a.m., MDS22 indicated Resident #11's wandering, rejection of care, and other behaviors were not coded on the Quarterly MDS assessment. MDS22 stated they believed that if a behavior was already addressed through care planning, it was not to be coded on the MDS assessment, even if it occurred during the 7-day look-back period. MDS22 stated they had received guidance from the Regional MDS Consultant regarding coding practices. During interview on 7/9/26 at 12:05 p.m., the Regional MDS Consultant indicated behavioral symptoms occurring during the 7-day look-back period should be coded accurately on the MDS assessment. The Regional MDS Consultant stated rejection of care that represented an established resident preference would not be coded; however, Resident #11 did not have a preference for rejection of care and should have had wandering and behavioral symptoms reflected on the Quarterly MDS assessment. During a follow-up interview on 7/9/26 at 12:20 p.m., MDS22 indicated they were aware that behaviors occurring during the MDS look-back period were required to be accurately reflected on the Quarterly MDS assessment. MDS22 acknowledged Resident #11's wandering and behavioral symptoms should have been coded on the assessment and stated the Quarterly MDS assessment would be modified to accurately reflect the resident's documented condition.		